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INTRODUCTION*

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THE plight of those who cannot afford the medical care they need is perhaps the most critical issue in American health care today. As the number of American people living at or just above the poverty line in America increases, so does the level of uncompensated health care in the nation. No sure relief is in sight.

Medical care of the needy regardless of ability to pay is, and always has been, an obligation of society and a function of government. Often, however, the burden has fallen upon health-care providers by default. In the not too distant past physicians took this responsibility for granted, as a part of their trust. In a less competitive time, hospitals were better able to absorb the costs of free care or to fund them with the aid of private gifts. Our sense of right and wrong simply will not allow us to permit people to suffer serious illness or to perish from want of needed medical care. Yet hospitals and

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clinics—like every thing else—run on money. Payrolls must be met and vendors paid for service to continue. And at a time when health-care costs cannot be met out of any but the deepest private pockets, a quarter of the nation's population has no health insurance at all or is inadequately covered. Even Medicaid—always a program of varying benefits based upon each state's level of commitment—has shrunk steadily over the years to the point where in 1984 it provided aid for only 38% of those below the poverty level. Many public hospitals have closed, others have been forced to curtail service, and voluntary nonprofit health care institutions find that revenue margins are either so small as to be ineffective or that balance sheets are so tight as to preclude the provision of charity care.

How can society rescue the hospitals which care for the poor if not the medically needy themselves? Has New Jersey, with its all-payer DRG system, found an efficient and ethical solution to the problem? This was the question before the symposium which Seton Hall University and the University of Medicine and Dentistry of New Jersey convened on June 20, 1985 at South Orange. Participants included speakers whose roles in devising or administering the New Jersey system gave them a special vantage on the issue. To bring their thoughtful papers to wide public notice is this volume's purpose.

The DRG system itself was designed to establish a specific flat payment rate for each type of patient admitted to a hospital. As implemented in New Jersey, however, the payments were modified, hospital by hospital, to include a percentage allowance to cover the costs of the uncompensated care that each individual hospital has traditionally provided. In theory, then, all New Jersey hospitals are compensated for all the care they deliver, because those who can and do pay for care in New Jersey have agreed—consciously or by proxy—to pay more than their fair share to meet this social purpose.

Is this, indeed, an efficient and ethical way of providing care to the indigent? Or does it amount, in effect, to a tax on the very hospitals which treat the poor—and thus must charge the most to everyone else? And concentrating solely on hospital care, as opposed to outpatient care, does not the New Jersey system encourage continuation of the least efficient means of medical service to the poor? Is there a better way?

The first paper to address these issues, by Scott Crawford of the New Jersey Department of Health, is a technical description of the New Jersey system, a discussion of the major policy questions it raises and, on the whole, a vote of confidence in the state's approach. The second paper, by Jeffrey

Wasserman, a Pew Health Policy Fellow at the Rand Graduate Institute, is less sanguine, presenting selected empirical findings on how the system has affected access to care—and for whom—and citing areas where additional research is necessary.

James A. Morone of Brown University next presents an excellent summary of the political process through which DRGs arrived first in New Jersey and later in the nation as a whole. There follows the text of a wide-ranging panel discussion on the issues, of which I was chairman and whose participants included Richard Mellman, a member of the federal Prospective Payment Advisory Commission; Michael Kalison, J.D., Partner Manager, Kalison, Murphy and McBride; Sister Jane Frances Brady, President, St. Joseph's Hospital and Medical Center in Paterson; Fred Koehler, Senior Vice President-Finance, Blue Cross of New Jersey; and Alfred A. Alessi, M.D., and John Capelli, M.D., New Jersey medical practitioners.

We had the further treat of hearing Joanne E. Finley, M.D., formerly New Jersey Commissioner of Health, reminisce on the nuts and bolts of building and installing the New Jersey system. Her remarks are also included in full. Finally, William Brandon, Ph.D., Associate Professor of Political Science at Seton Hall University—the guiding hand behind the seminar—asked, "Can DRG systems substitute for national health insurance?" and concluded that perhaps they can.

Physicians have long been heavily subsidized both in training and during their years of health care services. Hospitals too have depended greatly upon tax levies for capital resources and operating budgets. Even tax write-offs by corporations and fringe benefits enjoyed by employees have received benefit of tax deductions. As all these balances change and a new ethic evolves, we must remember our ethical obligation to our brothers and sisters. We as physicians can provide leadership in the restoration of a commitment to share our benefits, our good fortune, our publicly subsidized talents with the less fortunate members of our community. The humane response is required of us all—the challenge is to identify, to implement nationally and to fund on a stable long-term basis care for the poor.

I am pleased to introduce the proceedings of this most timely symposium. I trust this conference will contribute to resolution of this pressing issue, not only in New Jersey, but throughout the nation.